Oklahoma Health Care Authority # 807

Lead Administrator: Becky Pasternik-Ikard **Lead Financial Officer: Carrie Evans (CFO)**

FY'17 Projected Division/Program Funding By Source

	Appropriations	Federal	Revolving	Local	Other*	Total
Administration/Operations 10	$24,390,065	$26,751,368	$504,071			$51,645,504
Medicaid Payments - 20	$945,744,197	$3,067,894,204	$1,349,652,065			$5,363,290,465
Medicaid Contracts - 30	$9,023,428	$26,450,091	$7,683,980			$43,157,500
Premium Assistance (IO) - 40	$0	$50,870,664	$35,914,839			$86,785,503
Grants Management - 50	$97,500	$4,127,285	$0		$658,777	$4,883,561
ISD Information Services - 88	$11,795,324	$45,671,850	$4,093,038			$61,560,212
Total	**$991,050,514**	**$3,221,765,462**	**$1,397,847,992**	**$0**	**$658,777**	**$5,611,322,745**

*Source of "Other" and % of "Other" total for each.
TSET Provider Engagement Grant (42%), Tulsa Community Foundation Women's Health Fund (31%), and TSET Health Promotions Coordinator Grant (27%)

FY'16 Carryover and Refund by Funding Source

	Appropriations	Federal	Revolving	Local	Other*	Total
FY'16 Carryover	$39,042,831					$39,042,831
FY'16 GR Refund**	-$23,524,033					-$23,524,033
Funding for delayed pymt cycle	-$21,796,674					-$21,796,674

*Source of "Other" and % of "Other" total for each.

**Indicate how the FY'16 General Revenue refund was budgeted

The FY'16 GR refund was budgeted in the FY'17 Medicaid Payments, Activity 20. These funds will be paid to medical professionals providing services to SoonerCare clients.

Note: To balance the FY'16 budget, the agency delayed the last provider payment cycle until FY'17 when funds were appropriated for the cycle. This eliminates the agency's need for carryover replacement and allows $6,277,876 to be used toward other FY'18 budget needs.

What Changes did the Agency Make between FY'16 and FY'17?

1) Are there any services no longer provided because of budget cuts?
No

2) What services are provided at a higher cost to the user?
There were no changes between FY'16 and FY'17

3) What services are still provided but with a slower response rate?
N/A

4) Did the agency provide any pay raises that were not legislatively/statutorily required? If so, please provide a detailed description in a separate document.
No

FY'18 Requested Division/Program Funding By Source

	Appropriations	Federal	Revolving	Other	Total	% Change
Administration/Operations 10	$25,492,092	$28,011,061	$504,071		$54,007,224	4.57%
Medicaid Payments - 20	$1,136,959,603	$3,117,601,353	$1,358,286,655		$5,612,847,610	4.65%
Medicaid Contracts - 30	$11,858,385	$29,285,048	$7,683,980		$48,827,414	13.14%
Premium Assistance (IO) - 40	$0	$50,870,664	$35,914,839		$86,785,503	0.00%
Grants Management - 50	$97,500	$4,127,285	$0	$658,777	$4,883,561	0.00%
ISD Information Services - 88	$14,330,979	$70,925,768	$4,093,038		$89,349,785	45.14%
Total	**$1,188,738,559**	**$3,300,821,179**	**$1,406,482,582**	**$658,777**	**$5,896,701,097**	5.09%

*Source of "Other" and % of "Other" total for each.
TSET Provider Engagement Grant (42%), Tulsa Community Foundation Women's Health Fund (31%), and TSET Health Promotions Coordinator Grant (27%)

FY'18 Top Five Appropriation Funding Requests

		$ Amount
Request 1:	Annualizations - FMAP change/Medicare A&B Premiums (1/1/2017), CHIP	$93,939,197
Request 2:	Maintenance - Medicaid growth (1.8%), Medicare Part D, Contract Increases, FTE (11)	$30,417,123
Request 3:	Mandates - Security Governance Director, Provider Enrollment staff	$132,847
Request 4:	One-Time Funding - FY-16 Carryover & replace, less FY-16 GR surplus & delayed payment cycle	(6,277,876)
Request 5:	SoonerHealth+ ABD Care Coordination Program (HB1566)	$ 52,924,003
Top Five FY-18 Requests		**171,135,295**

How would the agency handle a 5% appropriation reduction in FY'18?

A reduction of 5% in the appropriation level amounts to a cut of $50 million state dollars. Coupled with the $118 million required to maintain the program at its current level, an additional reduction of $50 million would result in a funding shortage of approximately $168 million. Consequently, this equates to a total reduction of $408 million to the SoonerCare Program to achieve a 5% appropriation reduction.

With a three month lead time to meet the required public notification process, the agency would recommend a reduction of overall provider rates by approximately 20% to accommodate a 5% reduction in the FY-2017 appropriation base. Assuming an effective date of July 1, this provider rate cut would achieve savings of $168 million in state dollars and reduce the matching federal dollars by $240 million. Except for a limited number of individuals receiving services in long term care facilities, eligibility for adults has been lowered to the minimum allowed by Federal requirements. The federal statutory maintenance of effort requirement prohibits states from reducing the number of children in the program by reducing qualification standards and also limits the reduction of benefits for this group. Although some optional adult benefits can be reduced, this action would shift costs to mandatory benefit categories. For example, the elimination of the adult emergency dental extractions will shift additional costs to the mandatory hospital emergency room payments and other costs of treating conditions caused by dental infection. Therefore, any significant budget reduction could only be achieved by provider rate reductions.

Each one percent reduction in provider rates equates to a reduction of $8.6 million in expenditure of state funds. Therefore, a 5% appropriation reduction requires a 20% provider rate cut.

How would the agency handle a 7.5% appropriation reduction in FY'18?

A reduction of 7.5% in the appropriation level amounts to a cut of $74 million state dollars. Coupled with the $118 million required to maintain the program at its current level, an additional reduction of $74 million would result in a funding shortage of approximately $192 million. Consequently, this equates to a total reduction of $469 million to the SoonerCare Program to achieve a 7.5% appropriation reduction.

To achieve a 7.5% appropriation reduction, the agency would be held to the same restrictions and utilize the same option as described above; however the reduction in provider rates would be greater. Each one percent reduction in provider rates equates to a reduction of $8.6 million in expenditure of state funds. Therefore, a 7.5% reduction requires a 22% provider rate cut.

How would the agency handle a 10% appropriation reduction in FY'18?

A reduction of 10% in the appropriation level amounts to a cut of $99 million state dollars. Coupled with the $118 million required to maintain the program at its current level, an additional reduction of $99 million would result in a funding shortage of approximately $217 million. Consequently, this equates to a total reduction of $529 million to the SoonerCare Program to achieve a 10% appropriation reduction.

To achieve a 10% appropriation reduction, the agency would be held to the same restrictions and utilize the same option as described above; however the reduction in provider rates would be greater. Each one percent reduction in provider rates equates to a reduction of $8.6 million in expenditure of state funds. Therefore, a 10% reduction requires an 25% provider rate cut.

Is the agency seeking any fee increases for FY'18?

		$ Amount
Increase 1	N/A	$0
Increase 2	N/A	$0
Increase 3	N/A	$0

What are the agency's top 2-3 capital or technology (one-time) requests, if applicable?

We have no capital or technology requests at this time.

Federal Government Impact

1.) How much federal money received by the agency is tied to a mandate by the Federal Government?

None. Participation in the Medicaid Program is optional for states; however, if a state chooses to participate in Medicaid the federal matching funds received are tied to federal requirements.

2.) Are any of those funds inadequate to pay for the federal mandate?

In relation to the response in the previous question, Medicaid is funded with federal funds matching state funds. Therefore, by definition, the federal funds are inadequate.

3.) What would the consequences be of ending all of the federal funded programs for your agency?

Turning back federal Medicaid funds would leave only state funds to support the program. In FY-2017, State funds comprise about 43% of the total program expenditures that provide health care to nearly 1 million Oklahomans and has a $5.6 billion impact on the economy.

4.) How will your agency be affected by federal budget cuts in the coming fiscal year?

Under current law, Medicaid is included in the exempt mandatory spending. Therefore, any upcoming budget cuts will have no direct impact.

5.) Has the agency requested any additional federal earmarks or increases?

No

Division and Program Descriptions

Division I **Medicaid Program**

Medicaid is a federal and state entitlement program that provides medical benefits to low income individuals who have no or inadequate health insurance coverage. Medicaid guarantees coverage for basic health and long term care services based upon income and/or resources. Medicaid serves as the nation's primary source of health insurance for the poor. The terms on which federal Medicaid matching funds are available to states include five broad requirements related to eligibility. In order to be eligible for Medicaid, an individual must meet all of these requirements. The availability of federal matchings funds does not necessarily mean that a state will cover these individuals since the state must still contribute its own matching funds toward the cost of coverage. In exchange for federal financial participation, states agree to cover groups of individuals referred to as "mandatory groups" and offer a minimum set of services referred to as "mandatory benefits." States can also receive federal matching funds to cover additional "optional" groups of individuals and benefits. A detailed summary of the categorical eligibility standards as well as mandatory and optional benefits provided in Oklahoma can be found in the OHCA Annual Report. Additional performance information is available in the annually issued Service Efforts and Accomplishments Report.

FY'18 Budgeted FTE

	Supervisors	Classified	Unclassified	$0 - $35 K	$35 K - $70 K	$70 K - $$$
Operations - 10	111	0	494	21	394	79
Medicaid Payments - 20	0	0	0	0	0	0
Medicaid Contracts - 30	0	0	0	0	0	0
Premium Assistance (IO) - 40	5	0	37	4	30	3
Grants Management - 50	4	0	31	2	28	1
ISD Information Services - 88	14	0	43	1	34	8
Total	**134**	**0**	**605**	**28**	**486**	**91**

FTE History

	2017 Budgeted	2016	2013	2010	2006
Operations - 10	494.0	492.0	443.5	440.5	390.75
Medicaid Payments - 20	0.0	0	0	0	0.00
Medicaid Contracts - 30	0.0	0	0	0	0.00
Premium Assistance (IO) - 40	37.0	37.0	25.0	28.0	3.00
Grants Management - 50	31.0	36.0	23.0	19.1	3.75
ISD Information Services - 88	43.0	45.0	49.0	0.0	0.00
Total	**605.0**	**610.0**	**540.5**	**487.6**	**397.5**

Performance Measure Review

		FY'16	FY'15	FY'14	FY'13	FY'12
Goal 1 - Financing & Reimbursement						
1	Reimbursement as a Percentage of Medicare Rates	86.57%	89.25%	96.75%	96.75%	96.75%
2	Reimbursement to Hospitals as a % of Federal Upper Pymt Limit	94.19%	90.21%	87.96%	83.33%	85.24%
3	Average % Reimbursement for Nursing Home Costs per Patient Day	90.67%	92.66%	94.42%	89.00%	89.00%
4	Average % Reimbursement for ICF/ID Facility Costs per Patient Day	98.21%	98.85%	99.81%	100.00%	100.00%
5	# of Eligible Professionals Receiving an EHR Incentive Pymt	569	1,003	1,022	780	718
6	# of Eligible Hospitals Receiving an EHR Incentive Payment	16	70	55	46	44
7	Total EHR Incentive Pymts to Eligible Professionals/Hospitals	$10,640,175	$32,050,254	$32,553,188	$38,968,791	$44,062,545
8	% of Eligible Professionals in Compliance with Meaningful Use of EHR	64.7%	70.3%	61.0%	45.3%	3.8%
9	% of Eligible Hospitals in Compliance with Meaningful Use of EHR	100.0%	97.1%	98.2%	73.9%	4.5%
10	Avg SoonerCare Program Expenditure per Member Enrolled	$4,103	$4,260	$4,257	$4,077	$4,046
11	Total # of Unduplicated SoonerCare Members Enrolled	1,052,826	1,021,359	1,033,114	1,040,332	1,007,356
12	Average Expenditure per Insure Oklahoma Member Enrolled	$2,056	$2,365	$2,350	$2,670	$2,677
13	Total # of Unduplicated Insure Oklahoma Members Enrolled	32,574	28,397	40,261	45,855	48,616
14	Avg Monthly Enrollment in Health Access Networks (HANs)	116,553	121,891	109,194	64,730	50,295
15	Total # of HAN Member Months	1,412,479	1,462,695	1,310,322	776,756	603,545
16	Total Payments Made to HANs	$6,359,145	$7,063,475	$6,551,610	$3,885,990	$3,017,725
Goal 2 - Program Development						
	Health Management Program					
17	HMP Total Enrollment	4,544	4,297	5,355	1,394	4,130
	HMP Per Member Per Month					
18	Forecast PMPM	$1,127	$1,097	$1,075	$1,375	$1,405
19	Actual PMPM	$899	$979	$960	$1,125	$1,173
20	% Below Forecast	21.0%	11.0%	11.0%	18.2%	16.5%
21	HMP/Number of Providers with On-Site Practice Facilitation	44	41	33	50	53
	Chronic Care Unit					
22	Number of Unduplicated Members Enrolled	1,500	1,147	978	206	
23	Percent of Members with a Diagnosis of Hemophilia	7.4%	4.7%	10.1%	31.0%	
24	Percent of Members with a Diagnosis of Sickle Cell Anemia	1.4%	5.4%	12.9%	41.3%	
25	Percent of Members with a Combination of Chronic Conditions	91.2%	89.9%	77.0%	27.7%	
	Case Management					
26	Number of New High-Risk OB members	3,840	2,192	2,474	1,998	1,832
27	Number of New At-Risk OB members	1,278	459	618	637	713
28	Number of New Fetal Infant Mortality Reduction Outreach to Moms	1,795	1,694	1,781	2,041	2,274
29	Number of New Fetal Infant Mortality Reduction Outreach to Babies	2,245	2,059	2,138	2,100	1,713 (11 mos)

	Performance Measure Review				
	FY'16	FY'15	FY'14	FY'13	FY'12
Goal 2 - Program Development (Continued)					
Health Access Networks (HANs)					
30 Number of Contracted HANS	3	3	3	3	3
31 Total Number of Enrollees (at June 30)	117,750	133,471	118,107	90,688	61,078 (10 mos)
32 Number of Members Required to Receive Care Management	13,200	8,405	740	1,418	1,961
33 Number of Unduplicated Providers in HANs	767	698	584	484	309
SoonerCare Provider Network					
34 SC Choice Providers	2,719	2,558	2,309	2,170	1,933
35 SC Choice PCP Total Capacity	1,166,074	1,151,757	1,177,398	1,139,130	1,202,168
36 SC Choice PCP % of Capacity Used	41.96%	42.92%	42.26%	44.06%	37.85%
37 Percent of Tier 1 Entry-Level Medical Homes	52.91%	53.76%	56.90%	58.64%	64.88%
38 Percent of Tier 2 Advanced Medical Homes	24.88%	25.55%	23.98%	27.69%	26.37%
39 Percent of Tier 3 Optimal Medical Homes	22.19%	20.69%	19.12%	13.67%	8.75%
40 # of Tier 1 Advanced Medical Homes	472	486	503	502	534
41 # of Tier 2 Advanced Medical Homes	222	231	212	237	217
42 # of Tier 3 Optimal Medical Homes	184	184	169	117	72
Patient-Centered Medical Home Enrollment/Tiers					
43 Total # of SC Members Enrolled in Medical Home	529,917	548,162	560,887	539,670	479,492
44 % of SC Members Enrolled in Medical Home	67.23%	66.00%	70.00%	69.00%	63.00%
Member aligned with Medical Homes by Tier Level					
45 Percent of Members Aligned with Tier 1 Entry-Level Medical Homes	39%	40%	41%	42%	46%
46 Percent of Members Aligned with Tier 2 Advanced Medical Homes	28%	27%	28%	31%	31%
47 Percent of Members Aligned with Tier 3 Optimal Medical Homes	32%	34%	31%	27%	23%
48 Number of Members Aligned with Tier 1 Entry-Level Medical Homes	234,880	205,814	229,964	226,661	220,566
49 Number of Members Aligned with Tier 2 Advanced Medical Homes	169,374	144,334	157,048	167,298	148,643
50 Number of Members Aligned with Tier 3 Optimal Medical Homes	193,424	175,071	173,875	145,711	110,283
Goal 3 - Personal Responsibility					
% of Children Accessing Well-Child Visits/EPSDT:					
51 First 15 months	N/A	94.3%	96.3%	97.3%	98.3%
52 3 to 6 years	N/A	57.1%	58.5%	57.6%	57.4%
53 Adolescents	N/A	22.1%	21.8%	22.5%	34.5%
Adults Health Care Use - Preventive Care:					
54 20 to 44 years	NA	81.0%	82.4%	83.4%	83.1%
55 45 to 64 years	NA	90.1%	89.9%	89.8%	91.0%
56 Number of Medicaid Members Calling Tobacco Helpline	5,710	4,102	4,076	5,575	5,778
57 Number of Oklahomans Calling the Tobacco Helpline	34,339	24,879	22,251	35,123	38,732
58 Percent of Medicaid Members Calling the Tobacco Helpline	16.60%	16.49%	18.32%	15.87%	14.92%
59 Number Of Medicaid Members Utilizing Tobacco Cessation Benefits	28,464	26,783	21,610	23,581	25,098
60 EPSDT Participation Ratio	NA	60.0%	60.0%	56.0%	56.0%
61 Average # of Members in Pharmacy Lock-In	390	406	404	313	273
62 % of Members Seeking Prenatal Care	96.46%	97.74%	97.68%	97.32%	97.12%
63 # of Births	30,594	31,237	32,254	32,915	32,904
64 First Trimester	18,192	18,824	19,881	20,306	19,331
65 Second Trimester	8,091	8,077	8,088	8,289	8,890
66 Third Trimester	3,227	3,630	3,538	3,493	3,737
67 ER Visits per 1,000 Member Months (calendar year)	NA	NA	NA	N/A	73.5 (half yr)
Goal 4 - Satisfaction & Quality					
Customer Survey Results (CAHPS) Adults:					
68 Customer Service	87%	92%	82%	90%	
69 How Well Doctors Communicate	91%	90%	90%	87%	
70 Getting Care Quickly	84%	86%	82%	79%	
71 Getting Needed Care	85%	85%	82%	80%	
72 Shared Decision Making	77%	77%	50%	48%	
Customer Survey Results (CAHPS) Children:					
73 Customer Service	86%	86%	88%	77%	
74 How Well Doctors Communicate	97%	96%	97%	93%	
75 Getting Care Quickly	93%	92%	92%	93%	
76 Getting Needed Care	89%	85%	89%	72%	
77 Shared Decision Making	78%	78%	60%	52%	
Other					
78 % of 5-Star Facilities in Focus on Excellence	18%	20%	17%	18%	15%
79 % of 4-Star Facilities in Focus on Excellence	29%	19%	29%	29%	16%
80 % of Members Participating in the Resident Satisfaction Survey Rating Overall Quality as Excellent or Good	92%	93%	93%	94%	
81 % of Employees Participating in the Employee Satisfaction Survey Who Rate Overall Satisfaction as Excellent or Good	85%	87%	85%	88%	
82 % of Member calls answered	93%	90%	88%	86%	
83 % of Provider calls answered	97%	95%	92%	92%	
84 # Involuntary Provider Contract Terminations	62	100	95	43	59

Performance Measure Review						
		FY'16	FY'15	FY'14	FY'13	FY'12
Goal 5 - Eligibility & Enrollment						
85	Number of Online Enrollment Applications Received	383,914	210,571	291,323	437,668	440,091
86	% of Online Enrollment Applications That Are New	59%	60%	52%	55%	57%
87	% of Online Enrollment Applications That Are Recertifications	41%	40%	48%	45%	43%
88	Number of Online Applications Approved	331,918	179,782	253,723	320,105	Unavailable
89	Number of Online Applications Denied	51,916	30,789	37,830	117,563	Unavailable
90	Estimated Count of Eligible-But-Not-Enrolled Population (EBNE)	NA	54,255	58,699	64,965	64,860
91	Home Internet	70%	59%	59%	55%	48%
92	Paper	1%	5%	5%	5%	9%
93	Agency Internet	29%	35%	35%	26%	24%
94	Agency Electronic	0%	1%	1%	14%	20%
95	Telephone	0%	0%	Unavailable	Unavailable	Unavailable
Goal 6 - Administration						
96	Percent of Administration Budgeted Dollars Used	69.00%	64.00%	73.00%	65.79%	
97	Per Capita OHCA Administrative Cost	$116.65	$122.24	$138.96	$119.92	
98	Total Claims Paid	49,362,595	51,039,537	51,226,118	49,829,140	36,636,568
99	Payment Accuracy Measurement Rate (PAM)	94.78%	95.38%	97.64%	95.50%	
100	OHCA Payment Error Measurement Rate (PERM)		0.28%	0.28%	0.28%	0.28%
101	Number of Prior Authorizations Generated for Prescriptions	161,387	130,741	115,206	155,644	
102	Percentage of Manual Prior Authorizations for Prescriptions	62.74%	57.56%	77.90%	75.40%	
103	Payment Integrity Recoveries	$5,995,190	$4,524,690	$4,731,822	$3,404,767	$6,552,765
104	Number of Provider Audits	1159	611	285	133	
105	Number of Providers Referred to Medicaid Fraud Control Unit	1	0	0	1	
106	Third Party Liability Recoveries	$43,537,686	$39,050,461	$37,965,691	$53,212,491	$40,258,563
107	Number of SoonerCare Members with Third Party Insurance	158,337	162,886	160,271	163,006	
108	Percent of SoonerCare Members with Third Party Insurance	15.04%	15.95%	20.30%	20.60%	
Goal 7 - Collaboration						
109	Percent of Applications Submitted as Agency Internet and Agency Electronic Media Type	29%	37%	41%	40%	NA
110	State and Federal Revenue Generated by Collaborations to Provide Services	$1,441,259,300	$1,429,947,269	$1,292,233,657	$1,230,314,375	$848,660,601
111	State and Federal Revenue Generated by Collaborations to Provide Medical Education	$113,526,078	$140,931,567	$136,788,040	$126,057,898	$94,138,193
112	Number of Tribes Represented at Tribal Consultations	19	17	17	14	NA
113	Number of Tribal Partners Represented at Tribal Consultations (I/T/U and I.H.S.)	4	4	4	4	NA

Revolving Funds (200 Series Funds)			
	FY'14-16 Avg. Revenues	FY'14-16 Avg. Expenditures or Transfers	June '16 Balance
Fund 200 Administrative Disbursing Fund This fund is utilized for tracking revenues (federal & state) and expenditures for OHCA's administrative cost (except administrative cost of Fund 245-HEEIA). Normally, there are no transfers from this account, only transfers in. However, in the case of a federal disallowance, we have transferred from Fund 200 to Fund 240 (Federal Deferral Account). This is a revolving fund; balances are carried forward into the next fiscal year.	$140,249,384	$142,496,813	$18,092,568
Fund 205 SHOPP Fund This fund maintains the revenues and expenditures for the Supplemental Hospital Offset Payment Program. Transfers from this account are stipulated in House Bill 1381 with payments of $7,500,000 directed to Fund 340 on a quarterly basis. Also, included is a $200,000 yearly administrative expense. As of 1/1/14 SHOPP expenditures are processed	$232,232,570	$231,544,827	$2,067,340
Fund 230 Quality of Care (QOC) Revolving Fund This fund is utilized for posting of Assessment fees, penalties and interest. Expenditures for this fund were directed in HB 2019 to be for enhancements to specific Medicaid program rates of pay which included increases in the rate of pay for ICR/MR facilities, to the nursing facilities, to the nursing home rate of pay for eyeglasses and denture services, personal needs allowance increases, etc. These Medicaid program expenditures are processed through the Medicaid Management Information System which is budgeted and posted in mass to Fund 340. OHCA transfers money from Fund 230 to Fund 340 to replenish the fund for these enhanced costs.	$76,892,244	$76,912,085	$26,867
Fund 240 Federal Deferral Account Amounts are transferred in from different funds in anticipation of repayment of Federal Disallowances. Payments are not made from this account; amounts are transferred and paid from the account in which the disallowance is found.	$259,128	$3,333,333	$2,901,255
Fund 245 OEPIC Health Employee and Economy Improvement Act Revenue for this account includes tobacco tax collections, federal draws, interest income, and appropriations for prior year carryover. Expenditures passing through the fund are for managed program costs for employer sponsored insurance, managed care costs covered under the All Kids Act, individual plan service costs and administrative costs. Payments are processed through the Medicaid Management Information System which is budgeted and posted in mass to Fund 340.	$70,215,579	$64,358,815	$6,538,583
Fund 250 Belle Maxine Hilliard Breast and Cervical Cancer Treatment Revolving Fund This fund receives tobacco tax funds which may be budgeted and expended for the purpose specified and associated with the Oklahoma Breast and Cervical Act. This act established a new member group. The health services for this group are paid through the Medicaid Management Information System which is budgeted and in mass posted to Fund 340.	$813,043	$813,043	$0
Fund 255 OHCA Medicaid Program Fund This fund receives tobacco tax funds and those funds are transferred to Fund 340. This fund provided hospital rate increases, increase in number of physicians visits allowed, increase in emergency physician rates, enhanced drug benefits, dental services, etc. The health services for this fund are paid through the Medicaid Management Information System which is budgeted and in mass posted to Fund 340.	$48,730,402	$48,730,402	$0
Fund 260 Income Tax Check-Off Fund	$0	$0	$0